Special Needs Project
Screening Cover Form
Demonstration Site, County Commission

Please attach this form to the Screening Report Packets (# of packets attached:)

Child's name (if individualized):

Name of person who completed this form: | Phone number:

Program that provided screening (Select only one) *This section will be customized to list the programs providing screenings.*

Occupation of screener (Select only one)

☐ Audiologist	☐ Occupational therapist	☐ Social worker
☐ Child care provider	☐ Optometrist	☐ Special education teacher
☐ Early childhood teacher	☐ Paraprofessional	☐ Speech and language therapist
☐ Early intervention specialist	☐ Physical therapist	☐ Other
☐ Mental health professional	☐ Physician/pediatrician	☐ Unknown
☐ Nurse	☐ Psychologist	

Location of screening (Select only one)

☐ Family home	☐ Family resource center	☐ Hospital or clinic
☐ Child care setting	☐ Other community setting	☐ Unknown
☐ Preschool	☐ Early intervention classroom or center	